Patient Safety: The New Accountability

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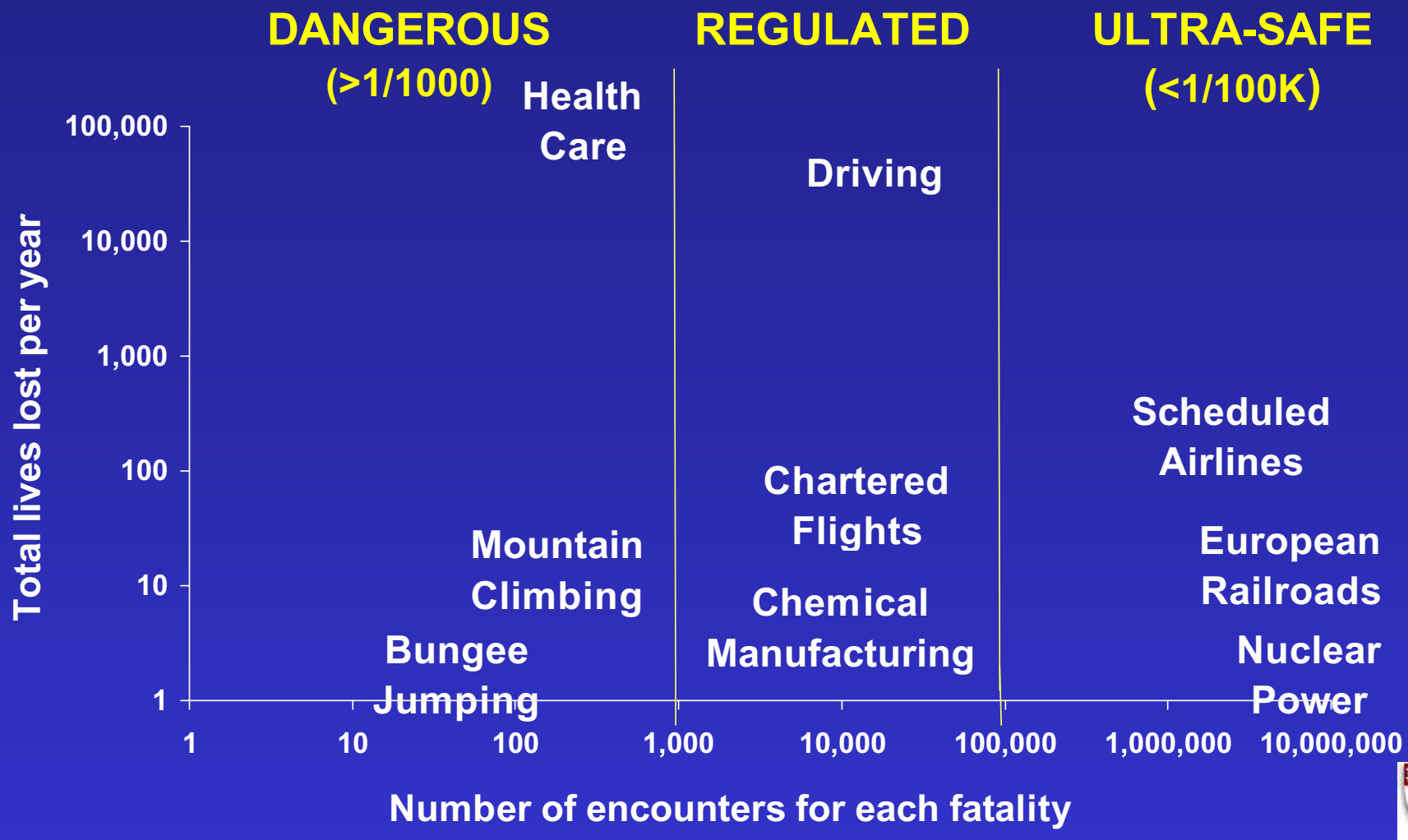
HARVARD SCHOOL OF PUBLIC HEALTH

How Hazardous Is Health Care?



The idea that medical errors are caused by bad systems is a transforming concept

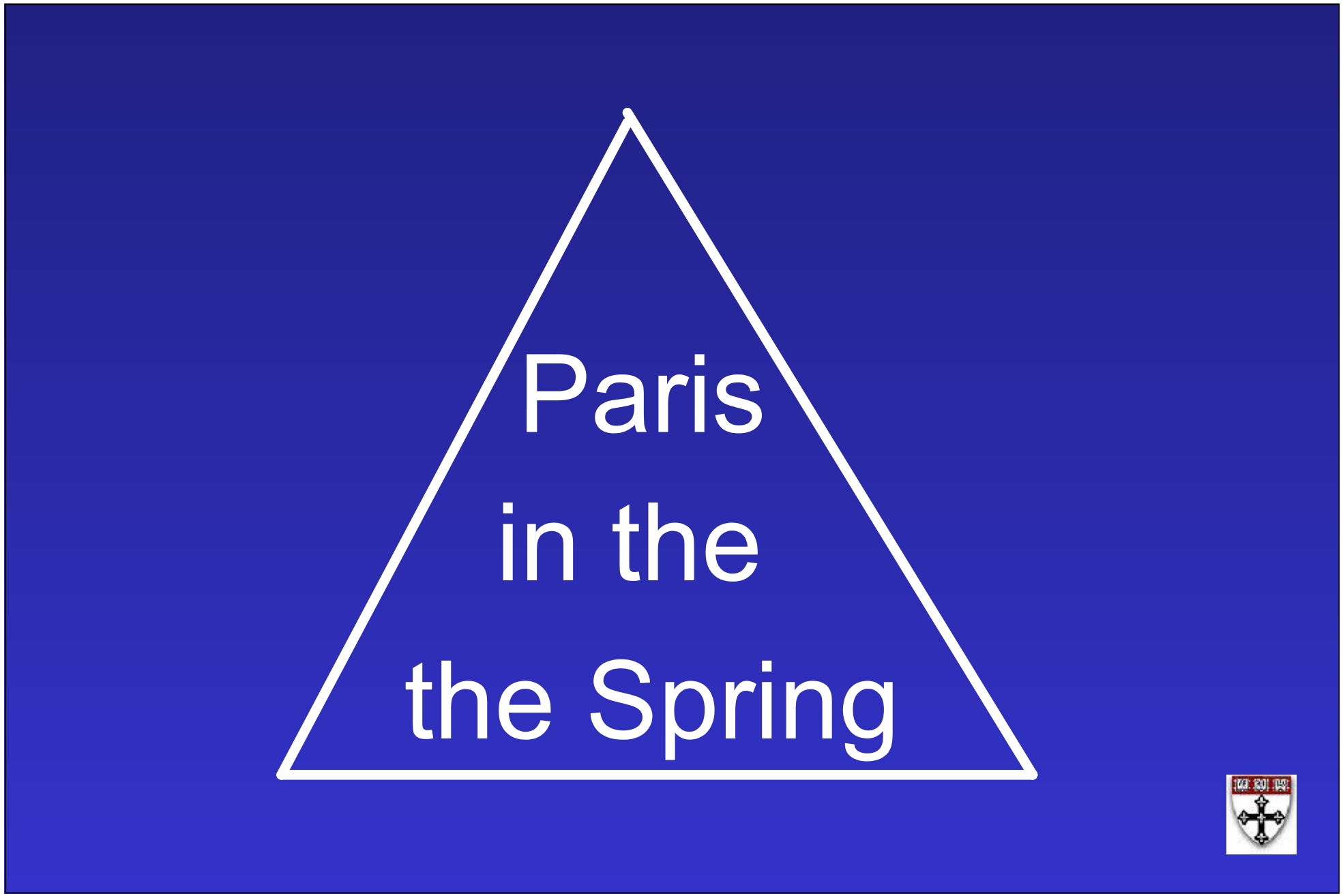
Latent Errors

Design characteristics that induce errors by:

a) Creating conditions that generate known causes of errors

OR

b) Requiring work that exceeds the capacity of the human brain


Paris
in the
the Spring

The Real Word

Healthy appearing decrepit 69 year old male, mentally alert but forgetful

The skin was moist and dry

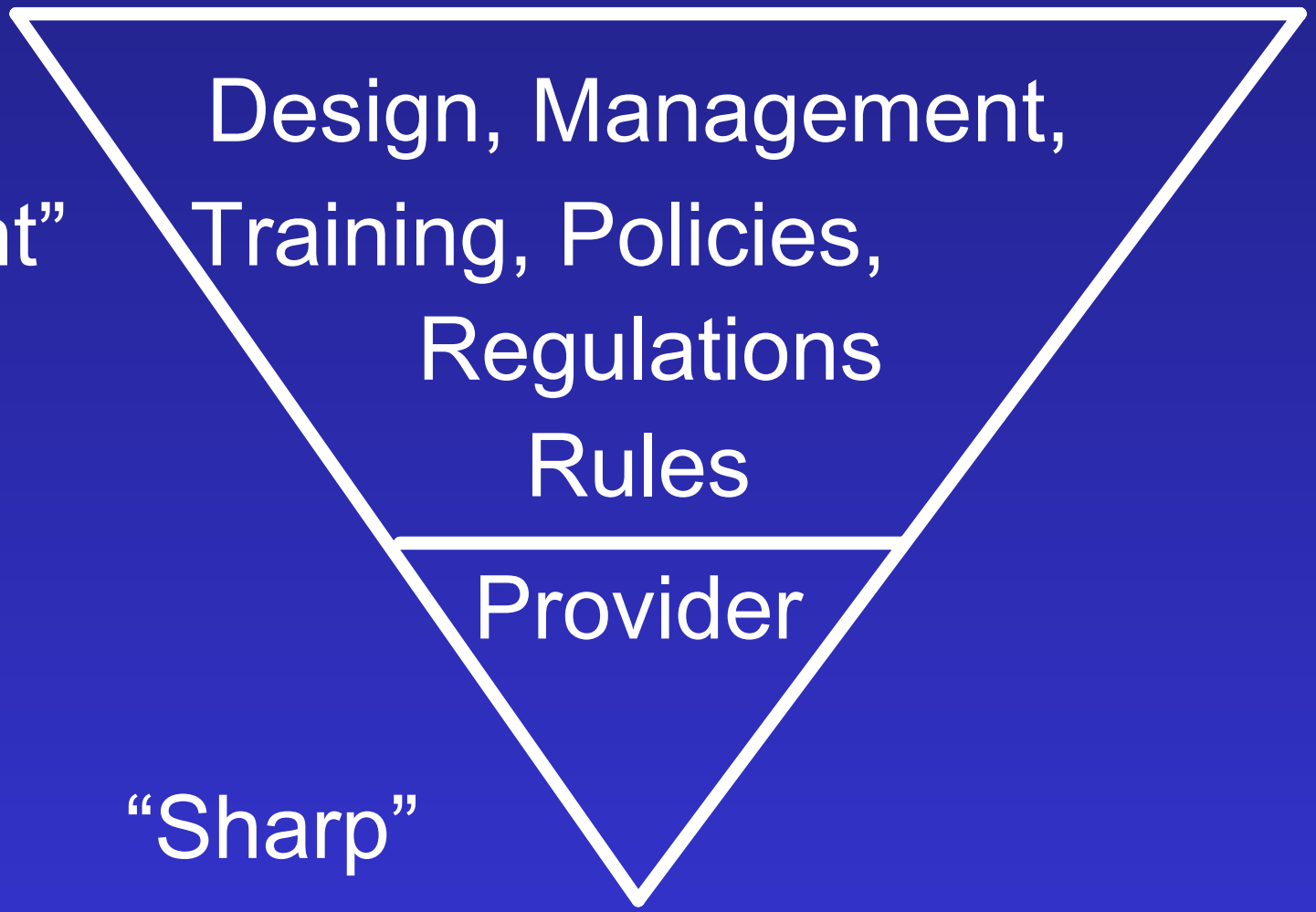
Occasional, constant, infrequent headaches

Patient was alert and unresponsive

Rectal examination revealed a normal sized thyroid

She stated that she had been constipated for most of her life, until she got a divorce

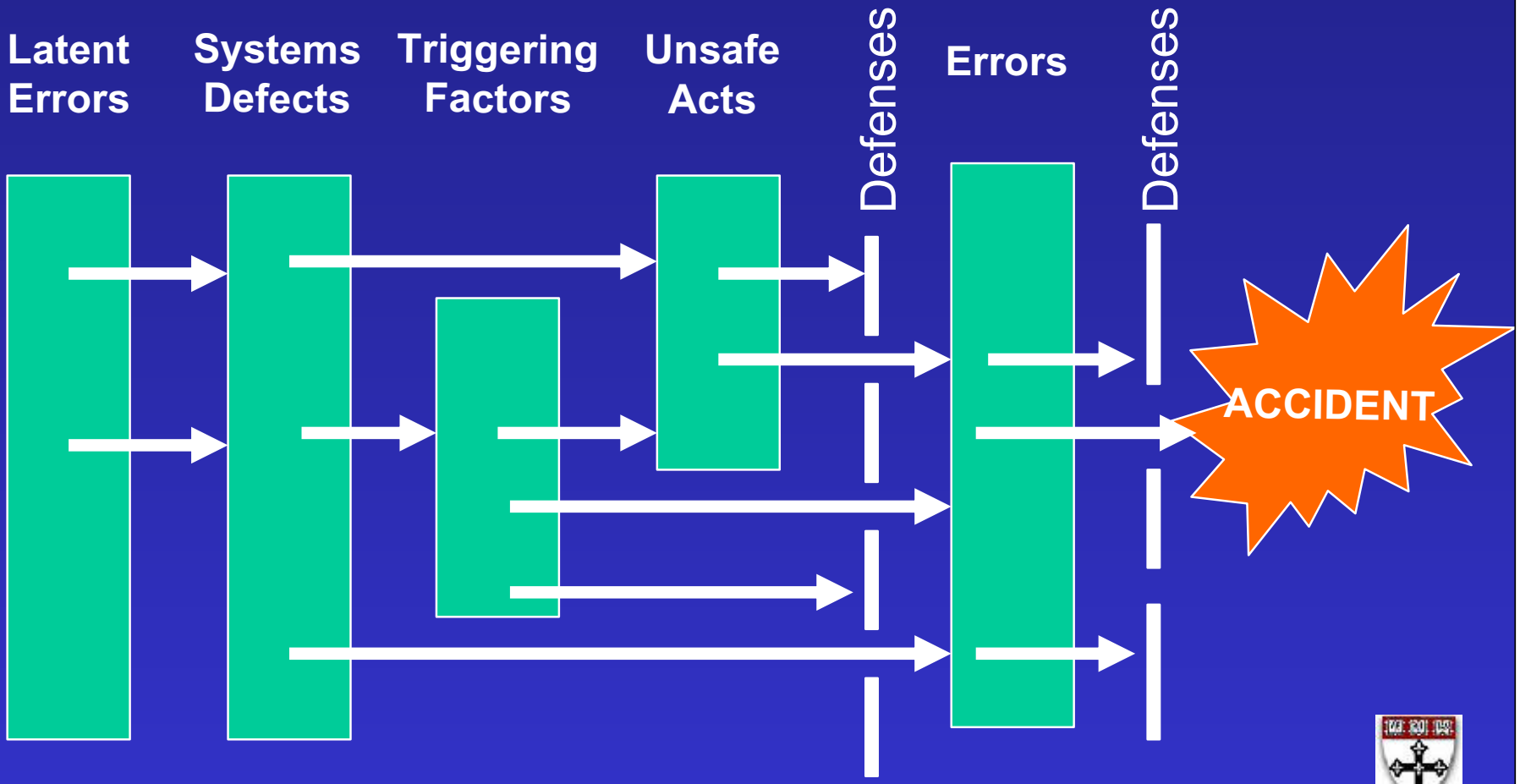
Levels of Safety



"Blunt"

"Sharp"

Accident Causation Model



Take-Home Messages

1) Medical injuries are not inevitable – most are preventable
2) They're not your fault – it's faulty systems
3) They are your responsibility
4) It's much easier to change systems than to change people

The Safety Challenge

- What's the right thing to do?

  (Has the practice been shown to be effective?)
- Have we done the right thing?

  (Implemented the practice)
- Have we done the right thing right?

  (Made sure that 100% get it, get it on time, and get it without mistakes)

Laboratory Systems Problems

- NOT quality of the testing – we assume it is excellent
- Inter-rater reliability of observational data (biopsies)
- Timely, efficient, guaranteed delivery, a la Fed Ex (lost specimens, delays)

Inter-rater Non-reliability

- Lack of reproducibility has been widely demonstrated in all types of human observation: X-rays, EKGs, biopsies, angiograms, mammograms
- Health care resists duplicate readings
- Costs LESS than not doing it
- Should be required for any test where missed diagnosis can be fatal

How are we doing?

Abnormal pap smears lost to follow-up	35%
Follow-up mammograms not done	37%
Dx-related malpractice suits due to lost follow-up	25%

Mass Coalition Safe Practices Project

- Safe medication practices dissemination in 2000 was an “incomplete success”
- Suspected reason was it was “top down”
- What does it take to get all hospitals to adopt a safe practice?

Selection of Safe Practices

- Solicited input from many stakeholders: “What keeps you awake at night?”
- Identified problems with safe practices
- Evaluated available safe practices for:
  - Evidence of effectiveness
  - Feasibility and measurability
  - Potential impact
- Stakeholder selection committee chose two
- Stakeholder consensus groups worked out the details

Proposed Topics

- Blood Transfusions
- Wrong-site surgery
- Falls
- Retained foreign bodies
- Pressure ulcers
- Surgical site infections
- Anticoagulation management
  - Coumadin
  - Heparin
- Reconciling medications
- Communicating critical test results

Communicating Critical Test Results

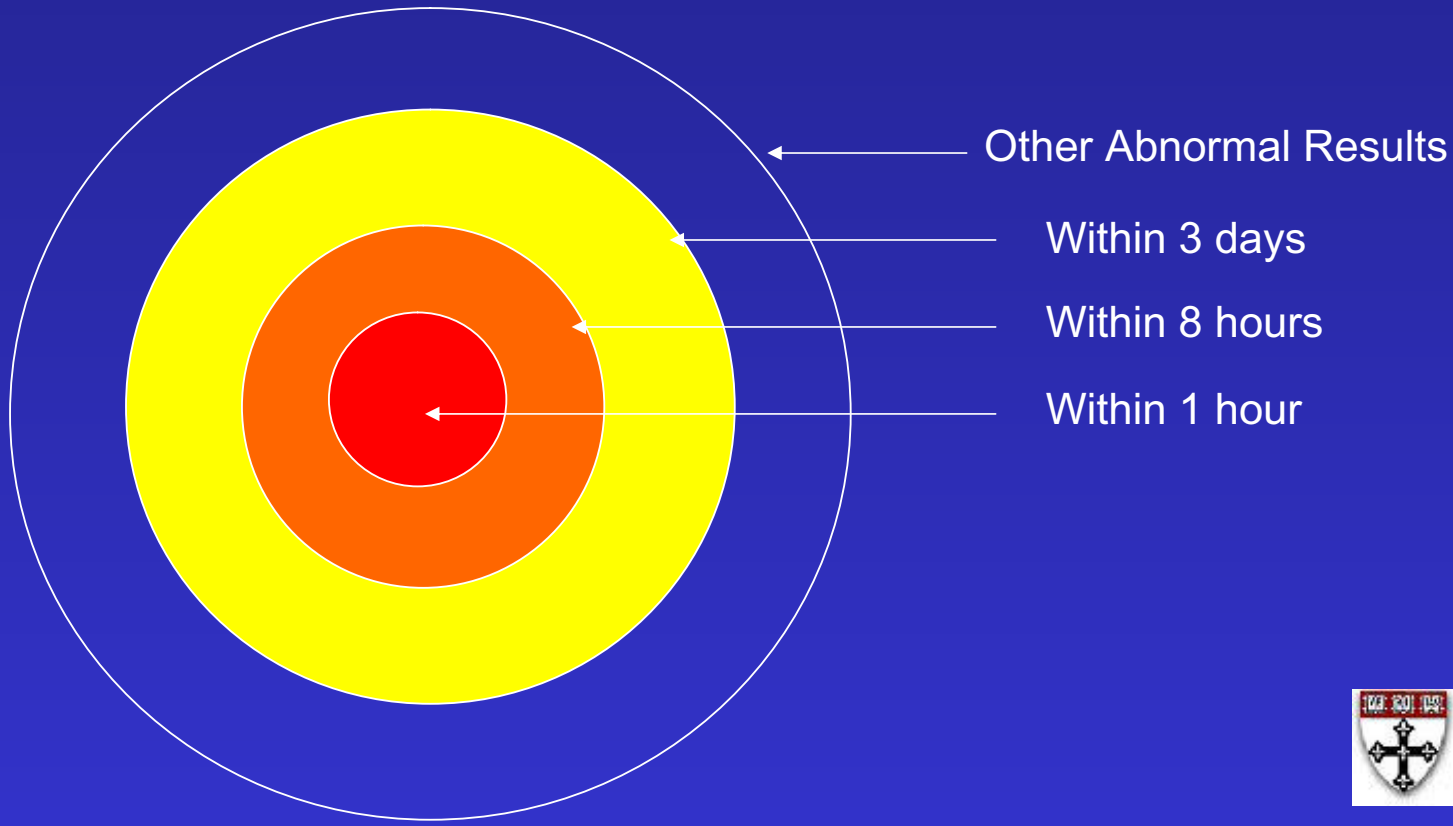
- Time till treatment 2.5 hours
  (25% longer than 5 hrs)
  (Kuperman, 1998)
- Appropriate treatment of life-threatening lab value 51%
  (Tate, 1990)

Communicating Critical Test Results

- What
- Who
- When
- How
- Who – Back-up
- Shared policy

Communicating Critical Test Results

What:



Communicating Critical Test Results

What:

- Extremes of anticoagulation requiring prompt change in dosage (INR > 10, PTT > 120)
- New dx of hematologic malignancies
- Life-threatening electrolyte disturbances
  - Extremes of K, Mg, Glucose
- Life-threatening radiology findings
  - Pneumothorax
- EKG suggestive of ST-elevation MI

Communicating Critical Test Results

What:

- Short list for Red Alerts
- Institution-wide standard for all users
  (Laboratory, pathology, radiology, cardiology)
- Applies to all sites – in-patient, emergency ward, doctors' offices

Communicating Critical Test Results

Who:

- Ordering MD has primary responsibility
  (Responsible for coverer)
- Results must go to a provider who can take action (i.e., usually not a nurse)
- PCP should also be informed

Communicating Critical Test Results When:

RED Alerts:

Explicit Protocol

- 1st to 1^0 MD
- 15 min: repeat
- 30 min: 2^0 MD
- 45 min: repeat
- 60 min: Fail-safe (ER, Sr resident, ICU)

Communicating Critical Test Results

How:

- Techniques that work in your hospital
- Telephone call preferred
- NOT to secretary or other intermediary
- NOT to answering machine or e-mail without receipt
- Full information: Pt, test, value, date, time, reporter, receiver
- Acknowledgement of receipt

Communicating Critical Test Results

Who (Back-up):

- Need an explicit protocol

  Patient should be linked at all times to an available physician
- Call schedule should identify correct MD – role-based system often best
- Centralized call center preferred
- Avoid “chain”

Communicating Critical Test Results

Shared policy

- Same time frames and colors (R-O-Y)
- Each discipline develops its own list in cooperation with clinicians
- Explicit fail-safe plan
- Explicit designation of responsible individual who communicates with physician
- Full documentation of each event

Communicating Critical Test Results

- Get the result to someone who can take action
- Have a clear back-up system with clear delineation of when to escalate
- Use a central call system
- Agree on which test results require communication
- Use the same policy across all domains

So, why aren’t we doing it?

Faced with the choice of changing one's mind and proving that there is no need to do so, almost everybody gets busy on the proof.

John Kenneth Galbraith

What do patients say?

Accountability = Responsibility

Not:

"Who's to blame?"

"Who's head shall roll?"

But:

"How do we make it happen?"

"What are the lines of responsibility?"

Accountability as Responsibility

- At the heart of the culture change we need to make health care safe
- Meaningful accountability is a collaborative, supportive, and reciprocal activity

Heart of Culture Change

- Must have clear responsibility to make the changes needed
- Responsibility for safety must trump personal preferences
- Safety is everyone's responsibility

Accountability as Responsibility

- At the heart of the culture change we need to make health care safe
- Meaningful accountability is a collaborative, supportive, and reciprocal activity

Reciprocal Accountability

Statutory Authority

v.

Moral Authority

Assumptions

- Doctors, nurses, all health workers, want to provide safe care
- Hospitals want to provide safe care
- Regulators want to use their power to help hospitals and staff provide safe care

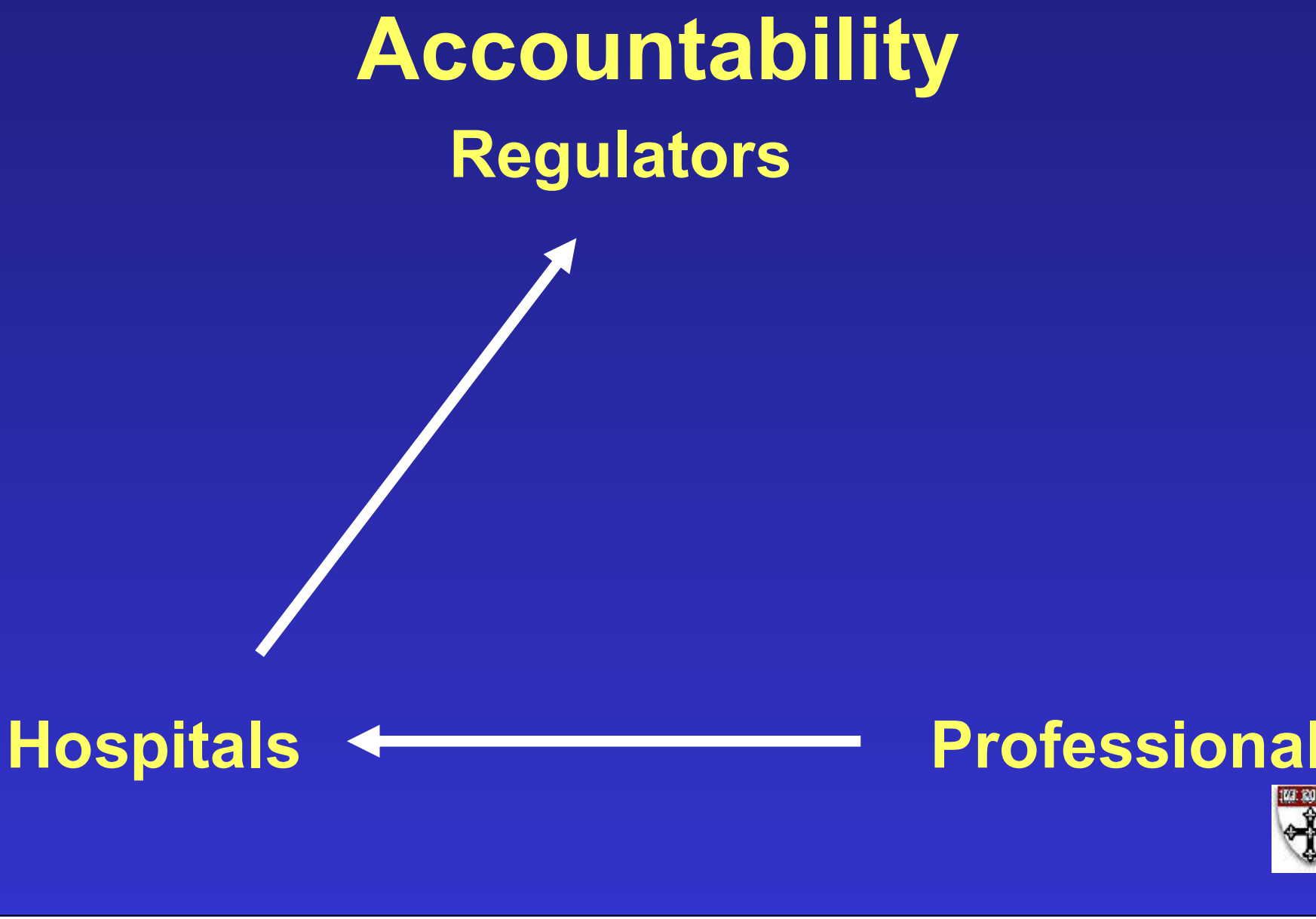
Accountability

Regulators

Hospitals

Professionals

Accountability



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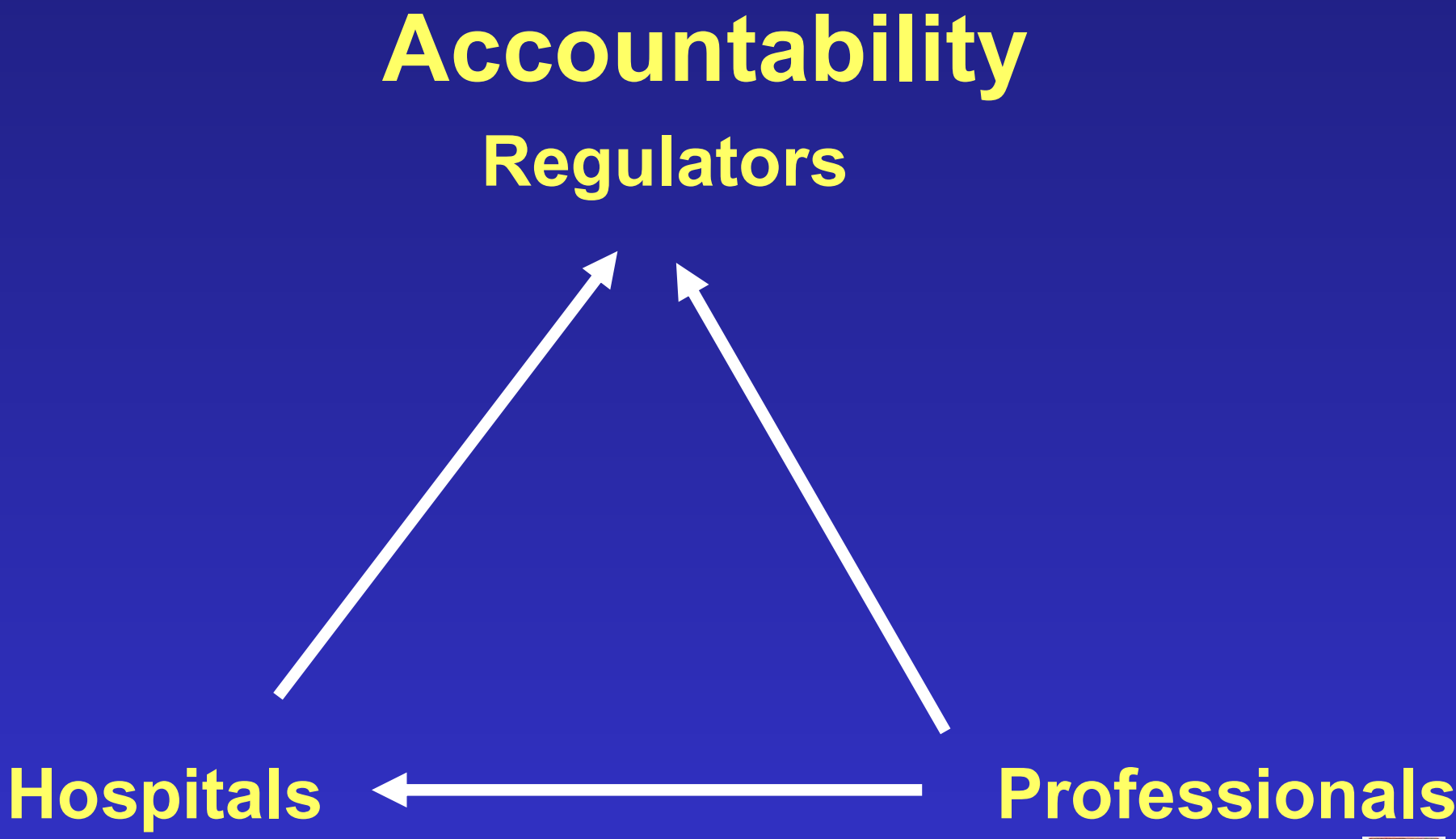

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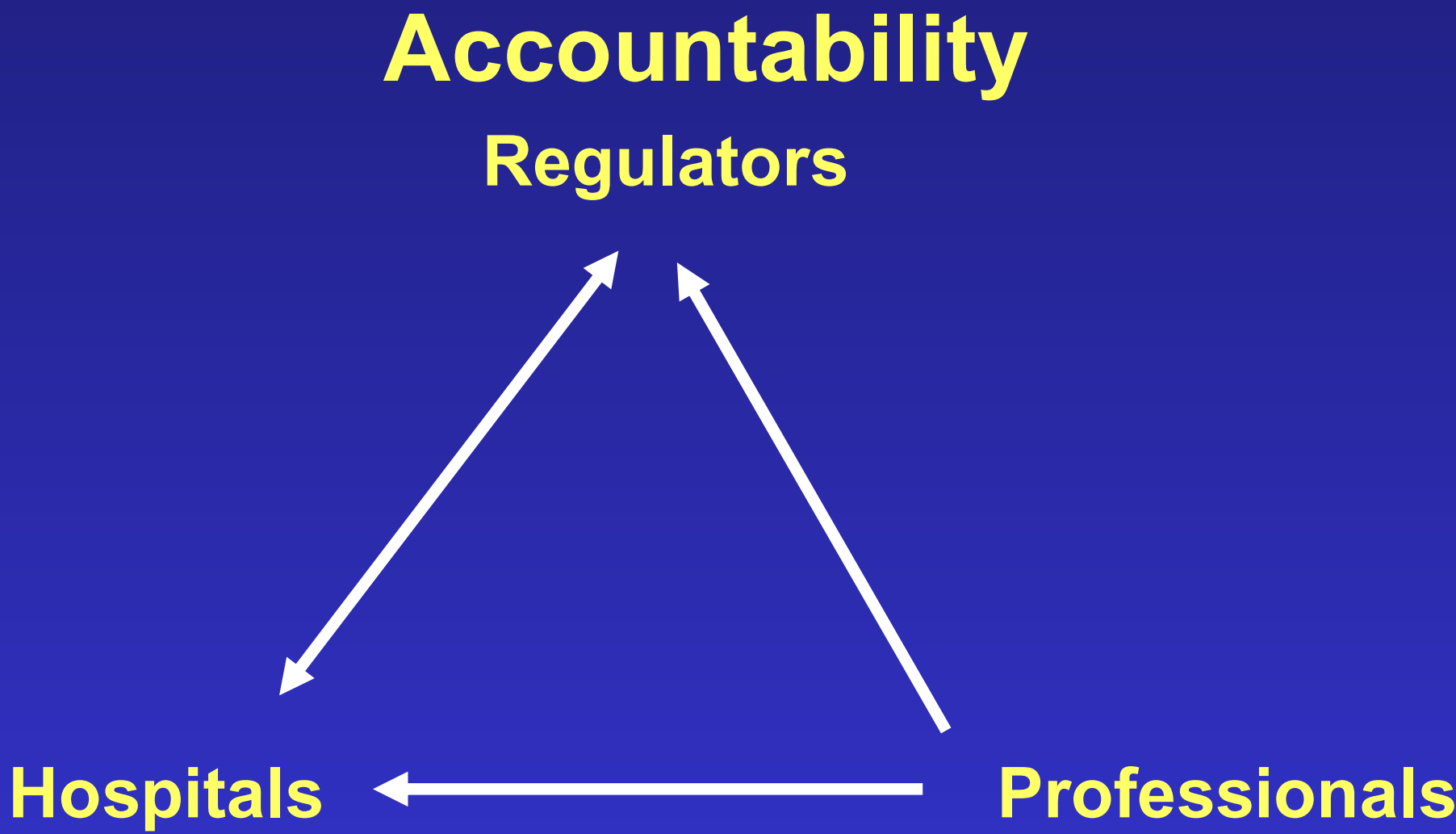

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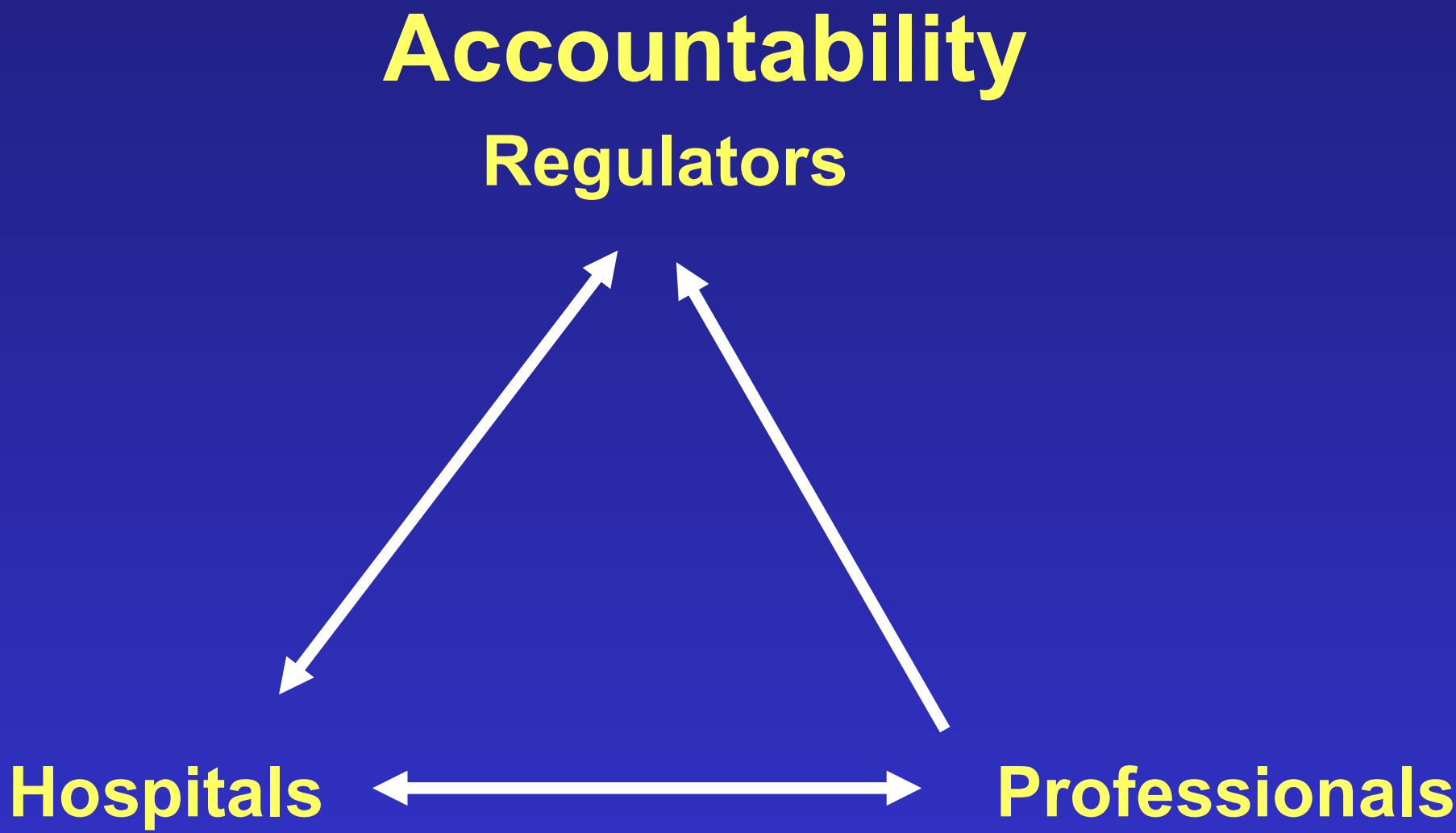

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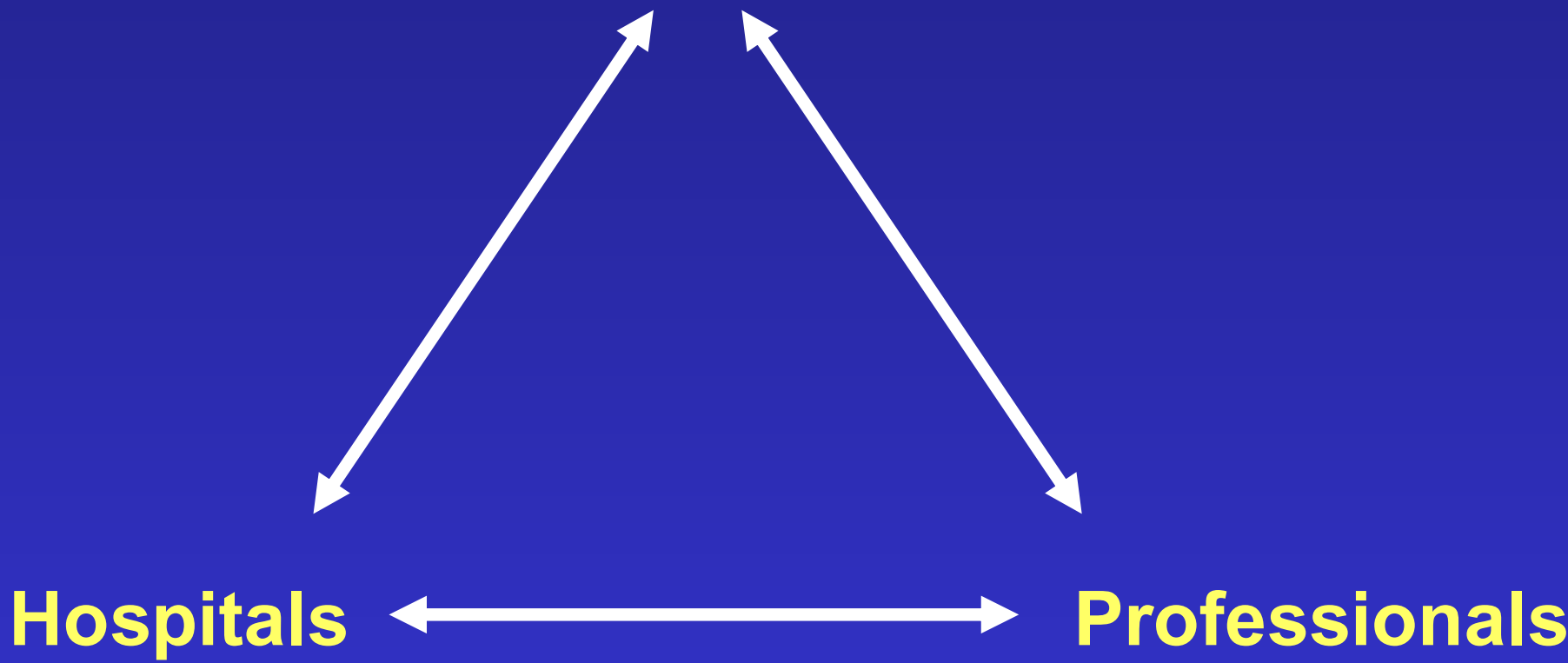

Accountability